

**Applicant Signature** 

## **BALTIMORE COUNTY GOVERNMENT RETIREE HEALTH INSURANCE APPLICATION**

1- Applicant's Personal Information											То Ве	Completed b	y the In	surance Div	ision		
Mana				04						Ber	Eff Date	:	I	OPOL:	•	•	
Name				Street						Dat	e of Even	t:	Ret	irement Dat	e:		
2011 (1				0.1		0.1				Ber	nefit Basis	:	I	Entity:			
SSN (L	ast 4)			City		State		Zip		Yea	ars of Cred	litable Service	:				
202					- "					Cor	npleted by	y:	Dat	te:			
DOB			Primary Phone		Email					IMP	ORTA	NT- Please	provi	de addr	ess fo	r	
If Spou	ise is Ap	plicant·		person(s) being removed:													
'	'		ree Name			Retir	ee SSN (Last	4)									
2- Enr	ollmer	nt Type															
Туре	f Ever	nt			Add Dependent(s)					Remove Dependent(s)							
Retirement					Open Enrollment	Marriage*					Leg	al Separation /	Divorce*				
New Applicant Gain of other coverage						Birth/Adoption of a Child*					Chil	Child over qualifying age					
Loss of other coverage						_	Other (please explain)					Other (please explain)					
* If add	ing or r	emoving dependen	t(s), please atta	ch docı	umentation within 31 da	ys of ev	ent *Ple	ase pro	vide addres	s for per	son(s) b	eing remove	<u>d</u>				
3- Ben	efit O	ptions															
Non-Medicare Retirees / Spouses							Dental Plans					Vision Plan					
Cigna Open Access Plus (OAP – In and Out of Network)  Cigna High Deductible Health Plan (HDHP)							CareFirst BCBS Traditional Dental					CareFirst Davis Vision					
Cigna Open Access Plus In-Network Only (OAPIN)							CareFirst BCBS Preferred PPO					Waive Coverage					
Kaiser Permanente Select HMO							Cigna Dental HMO										
Waive Coverage							Waive Coverage										
Coverage Level: IND Ret+Sp P/C FAM						Cover	age Level :	IND	Ret+Sp	P/C F	AM Cov	erage Level :	IND	Ret+Sp	P/C	FAM	
4- De	pende	nt(s) Being Add	ed or Remov	ed (Re	em)												
Name Add Rem				d Rem	Relationship		Gender Social			Security #	ŧ	Date of	Date of Birth			Disabled Y/ N	
RETIRE	Ē				SELF											1	
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eligibility r	ules set	forth in the Retiree e			t of my knowledge. I agr	ee to fol	low the Reti	ree guid	delines and	Return	40 Te b	altimore Cou 00 Washing owson, MD ocbenefits@	ton Ave 21204 baltimo	e Room 1 precountyr	11 nd.go	۰V	
<b>Applican</b>	t Signa	ture		Date	te					F	ax: 410-887	-3820	Ph: 410	-887-2	2568		